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	155417	A. BUILDING 00 B. WING	09/09/2011

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HICKORY CREEK AT SCOTTSBURG	1100 N GARDNER AVE SCOTTSBURG, IN47170

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F0000	This visit was for a Recertification and State Licensure Survey. Survey Dates: September 6, 7, 8, and 9, 2011 Facility Number: 000421 Provider Number: 155417 Aim Number: 100288340 Survey Team: Gloria J. Reisert MSW TC Dorothy Navetta RN Census Bed Type: SNF/NF: 31 Total: 31 Census Payor Type: Medicare: 06 Medicaid: 20 Other: 05 Total: 31 Sample: 10 Supplemental Sample: 10 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 9/14/11	F0000	**This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.** **Hickory Creek at Scottsburg desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on October 9, 2011.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0244 SS=E	Cathy Emswiller RN When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on record review, observation and interviews, the facility failed to resolve concerns regarding food preferences during 1 of 1 confidential group meetings with 6 alert, oriented and reliable residents, 1 of 3 resident interviews, 1 of 8 Resident Council minutes and 1 of 2 meal observations (Residents #50, 51, 52, 53, 54, 55, and 56) Finding includes: Review of the 4/1/2011 Resident Council minutes on 9/7/2011 at 1:00 p.m., indicated the following concern voiced and the Dietary Manager's response:" Concern: Menus written and returned by resident or staff, however meals on menus not the same as ordered. Too many replacements. Response: Most of the replacement are due to diet or residents preferences. Will strive to have exactly what is on the menu each day. Will try to only have minimal replacements. Was using up stock before starting new menus." During the confidential group meeting on	F0244	**F244** **It is the policy of this facility to listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility including residents' choice regarding food preferences.** **1.What corrective action will be accomplished for those residents found to have been affected by the deficiency?** Menus for every resident were checked to verify that each resident received what each one chose. If the resident's selective menu paper is not returned to the kitchen or the selective menu paper is incomplete, a staff member will take a selective menu to the resident prior to serving to allow his/her choice of the food that is being served. Alternate food choices will be promptly discussed with and provided to each resident. The Resident Council concern from the April minutes was under the responsibility of the previous Dietary Services Manager. A Teachable Moment (discipline) has been given	10/08/2011

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	9/6/2011 at 2:00 p.m., 6 of 7 residents (Residents #50, 51, 53, 54, 55, and 56) deemed alert, oriented and reliable by the Director of Nursing [DoN] on 9/9/2011 at noon, voiced the following concerns: not always following the selective menus choices, seldom bring what was ordered, run out of dessert ordered when get to the last table, and frequent excuses and substitutes. During an interview with the Activity Director on 9/7/2011 at 12:05 p.m., he indicated that according to the facility's Angel Program, each department head had 4 people that they were responsible for. Each department head was supposed to go back and check to make sure the resident had turned in their menu and had filled in all the choices. He indicated sometimes the residents forgot and left it on their table which was why their assigned person was supposed to go behind and check. He also indicated that if the resident left a section blank, i.e. the vegetable, meat, etc. then they got the * [star] item whether it was to their liking or not. He indicated he felt that this may be one of the reasons the resident thought they were getting something they did not order. The Activity Director indicated that he did not write down when the residents had		to the current Dietary Services Manager regarding the need to honor residents' food preferences. All Staff were re-educated on Sept.20, 2011 regarding promptly resolving concerns for food preferences. Activity Director and Dietary Manager were re-educated on Sept. 19, 2011 regarding follow up to concerns written from Residents Council. **2.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** All staff was educated on 9-20-11 to monitor residents' selective menus and to ensure that items selected are what are received. Meal delivery staff will check each individual resident's menu against what is being served as trays are delivered. If the meal delivery staff finds that a resident has not been served food according to his/her choice, the staff will take the food back to the dietary department, ask for the proper replacement as indicated by the resident's choice, and deliver it to the resident. Once that is done, the Dietary Service Manager will review the need for	

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	food complaints unless it had to do with Resident Council. He would instead go directly to the Dietary Manager and let her know of the concerns. During the noon meal observation on 9/7/2011 at 12:15 p.m., Resident #52 was brought her tray. Among the items she received was stewed tomatoes. During an interview at that time, the resident indicated she did not order stewed tomatoes and did not like the Brussels sprouts also on the menu. When asked if she was able to write on her menu if she did not like what was listed, she indicated yes but that she had help by her assigned Angel this time in filling out her menu. 3.1-3(l)		following the selective menus as designated by the resident with the staff involved in the noncompliance. Progressive disciplinary action will be done for instances of continued noncompliance. **3.What measures will be put into place to ensure this practice does not recur?** The DSM or designee will review the selective menus the day prior to the scheduled meals to ensure no replacements will be needed. If the DSM identifies food choices that are not readily available she will make sure that item(s) are purchased promptly. Any necessary menu changes will be completed prior to printing of selective menus and posting of meal for the day. Dietary Service Manager or her designee/cook for each meal will come into dining rooms and assess that residents are satisfied with food received. The DSM will address any identified issues with the staff as indicated in question #2. **4.How will corrective action be**	

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			monitored to ensure the deficient practice does not recur and what QA will be put into place? Through the facility Angel Program, department managers assist residents as needed with completing their menus and ensuring they return to the kitchen prior to the day the meals are to be served. Residents who prefer to complete the selective menus on their own will continue to be encouraged to do so. Residents who prefer not to complete their selective menus or who are unable to do so on their own will receive assistance of staff. With a resident concern, the DSM or designee reviewing selective menus and meals will pull paper menus. After resident needs are met, staff will document concern to assist in tracking with the QA audit form F244. Concerns documented on the paper menus, will be brought to the next daily interdisciplinary team meeting for review. The QA audits will be brought to the monthly QA&A Committee meeting that is attended by the medical director for review and recommendations. The QA audit form F-244, will be completed weekly for the next month, then twice a month for the next 30 days. After that time, it will be completed once a month on an	

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			ongoing basis until the facility has achieved 100% compliance. At that point, the QA&A Committee can decide whether or not to continue the written audit documentation. This process and review of the daily selective menus will continue on an ongoing basis even when documented audits are no longer required by the QA&A Committee. **Date of compliance: October 8, 2011.**	
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to follow physician's orders to decrease the dosage for 1 of 1 resident's anti-inflammatory medication.. (Resident #6) and to administer the antipsychotic medication as ordered (Resident #26). The facility also failed to ensure daily pulse checks were completed as ordered by the physician. (Resident #28). This deficient practice affected 2 of 10 residents in a sample of 10 residents and 1 of 1 residents in a supplemental sample of 10 residents reviewed for medication and vital sign orders.	F0282	**F282** **It is the policy of this facility that services must be provided by qualified persons in accordance with each resident's written plan of care including the need to follow physician orders for medication administration and vital signs.** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** 1. Medication (Motrin) for Resident #6 was added to the Medication Administration Record on August 30, 2011.	10/07/2011

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	Finding includes: 1. Review of the clinical record for Resident #6 on 9/8/2011 at 10:05 a.m., indicated the resident had diagnoses which included, but were not limited to, cerebral palsy, osteoarthritis, immobility syndrome, and osteoporosis. On 8/22/2011, the consultant pharmacist made the following recommendation: "[resident] has been receiving Motrin [a non-steroid anti-inflammatory drug] 400 mg [milligram] BID [twice daily] since 8/08 for Osteoarthritis pain, I presume. She also receives Aspirin 81 mg QD [daily] for cardiovascular prophylaxis. Please re-evaluate long term use of Motrin, especially as she is getting older now. Long term use is associated with elevated blood pressure, worsening kidney function, cardiovascular events and GI [gastrointestinal] effects." On 8/26/2011, the physician agreed and gave a new order to decrease the Motrin to 200 mg po [by mouth] BID. Review of the August MAR [Medication Administration Record] indicated the order was not put into effect until 8/30/2011. During an interview with the Director of Nursing [DoN] on 9/8/2011 at 2:00 p.m., she indicated one of the nurses'		2. The MD was notified of pulse checks for Resident #28 on 9/9/11. MD gave a new order to discontinue daily pulse checks and to check pulse every other day with Digoxin on 9/9/11. 3. Medication Administration Record was corrected for Resident #26 order for Seroquel on 9/7/11. The DON will provide re education to the nurses/QMAs on 9/28/11 to include review of Pharmacy recommendations and transcription of orders for medication changes and vital sign monitoring. **2. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken?** 1. A Pharmacy recommendation audit was completed on 9/12/11. No other residents were found to be affected by this alleged deficient practice. 2. & 3. An audit will be conducted by 9/30/11 on all monthly rewrites to make sure that they are accurate in preparation for the review of the October monthly physician orders. As the DON is reviewing the September monthly physician orders and any physician orders subsequent to it, she will identify any issues or concerns regarding physician orders and will make sure that the physician	

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	found the consultant's recommendation and the physician's response on a clip board 4 days later which was why the medication was not reduced until 8/30/2011. 2. Review of the clinical record for Resident #28 on 9/7/2011 at 3:15 p.m., indicated the resident had diagnoses which included, but were not limited to, coronary artery disease, atrial fibrillation and hypertension. The 2011 September monthly physician orders indicated the resident had an order dated 7/19/2010 for pulse checks every day. Review of the May to August 2011 MARs lacked documentation of the pulse being monitored on a daily basis. Review of the MARs indicated the pulse was only being monitored every other day due to the use of Digoxin [for heart]. During an interview with the DoN on 9/9/2011 at 11:00 a.m., she indicated she was not aware the pulse was not being monitored daily per physician orders and would need to call the physician to determine the reasoning for it being monitored daily and if he wanted it to continue to be monitored daily.		is notified, as necessary, for clarification. Once the orders are complete and accurate, the DON will review the facility's policy for transcription and following of physician orders with the nurse(s) involved. She will also render progressive disciplinary action for continued noncompliance. **3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** 1. The DON will review the 24 hour report, focus charting, Medication Administration Record, and Physician orders at least five times a week as part of her daily tour of duty. 2. Pharmacy recommendations will be given to the nurses to fax to the MDs. The MDs that do not receive faxes will be called in regards to the recommendations. If no response is received within 24 hours, the Physician will be contacted by phone for follow up. The DON will in-service all licensed nurses on this policy on 9/28/11.	

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			At least five days per week, the DON or designee, will review the 24 hour report, focus charting, Medication Administration Record, and Physician orders for any outstanding recommendations or change of orders. The DON or designee will document findings on audit tool QA audit form F282, five days per week. If the DON identifies recommendations not addressed by the Physician or new orders not processed, she will immediately ensure the attending Physician is notified and process any orders. Once they have been corrected, the DON will re train the staff member(s) involved. In addition, progressive disciplinary actions will be taken for non compliance. **4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** The DON or designee will bring the QA audits to the clinical review meeting 5 days a week. In addition,	

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	3. On 9/7/2011 at 4:30 p.m., during an observation of the medication pass, Resident # 26 did not receive her Seroquel 25 m.g. (milligrams) po (by mouth). In an interview with RN (Registered Nurse) # 1 at this time, she indicated that Resident # 26 was supposed to get Seroquel 25 m.g. and that when they attempted to decrease the dosage from 25 m.g. down to 12.5 m.g., the patient became so tearful, so they had to increase it back to 25 m.g. RN # 1 indicated that resident requested the Seroquel be given at 5:00 p.m. On 9/7/2011 at 5:00 p.m., review of the clinical record for Resident # 26 indicated diagnoses included, but were not limited		the results of the QA audit tool will be reviewed weekly at the Standards of Care meeting and monthly at the QA committee meeting for the next 3 months. The QA committee will determine the continued frequency of the QA audit tools after the 3 month time period once the facility demonstrates 100% compliance. However, the review process as outlined above will continue on an ongoing basis, even when the Committee no longer requires a written audit. Date of compliance is October 7 th , 2011.	

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	to; Alzheimer's dementia, psychosis, and dementia with behaviors disturbances. The Medication Administration Record (MAR) lacked documentation that any Seroquel had been given from 9/1/2011 to 9/7/2011. The MAR indicated, but was not limited to: on 8/26/2011 Seroquel 25 m.g. had been crossed out with a yellow highlighter and the letters D/C'D (discontinued) written across it. Physician orders indicated, but were not limited to; "8/26/2011 decrease Seroquel to 12.5 mg Q (every) HS (at bedtime)". On 8/26/2011, the order for Seroquel 12.5 m.g. had been added to the MAR. Physician orders indicated, but were not limited to; on "9/1/2011 ↑ (sign for increase) Seroquel to 25 mg Q HS". The MAR indicated on 9/1/2011 that the Seroquel 12.5 m.g. had been crossed out with a yellow highlighter and the letters D/C'D written across it. Documentation was lacking that the Seroquel 25 m.g. was added back on the MAR. A physician order dated 9/7/2011 indicated that the Seroquel may be given at 5:00 p.m. 3.1-35(g)(2)			

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F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on observation, interview and record review, the facility failed to ensure hazardous materials were secured properly on 1 of 4 survey days. This deficient practice had the potential to affect 2 of 10 residents (Residents #26 and 30) and 6 of 10 supplemental residents (Residents #3, 11,19, 24, 28 and 31) identified as ambulatory with dementia in a census of 31 residents currently in the facility. B. Based on record review and interview, the facility failed to ensure a bruise was thoroughly investigated for causative factors for 1 of 10 residents reviewed for skin impairments in a sample of 10 residents. (Resident #6) Findings include: A. After the group meeting on 9/6/2011 at 3:05 p.m., the following was observed in an unlocked cabinet with the key in the lock in the therapy room/ambulatory dining room:	F0323	**F323** **It is the policy of this facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents including securing of hazardous materials and thorough investigation of resident injury, such as bruising.** **1.What corrective action will be accomplished for those residents found to have been affected by the deficiency?** A. The cabinet was immediately locked and key removed from the lock. Therapist immediately notified of incident and directed not to leave key in lock when out of the room. B. Per interview of alert and oriented resident #6, res. indicates that during a transfer she was pinched by the mechanical lift which caused a bruise when assisted to the bathroom. All incident reports will be audited for the last 6 months to ensure that all incidents have been thoroughly investigated and if possible, causative factors identified by Sept. 30, 2011.	10/08/2011

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	1. a 4 fluid ounce bottle of Derma Tech Instant Hand Sanitizer. Review of the Material Safety Data Sheet [MSDS] presented by the Administrator on 9/7/2011 at 10:00 a.m., indicated: "May cause eye irritation. May cause upset stomach, nausea. Store at normal temperature away from reach of small children. Will cause slippery surfaces." 2. a 12 fluid ounce bottle of So Natural Body Lotion. Review of the label on the bottle indicated "Keep Out of Reach of Children". 3. a 12 fluid ounce bottle of Provon Moisturizing Hand And Body Lotion. Review of the Material Safety Data Sheet [MSDS] indicated: "May cause eye irritation. May cause upset stomach, nausea. Store at normal temperature away from reach of small children. Will cause slippery surfaces." 4. a 8.5 fluid ounce bottle of Conductor Transmission Gel. Review of the Material Safety Data Sheet [MSDS] indicated: "Irritation of the skin and eyes upon prolonged contact. Keep Out of Reach of Children." 5. a 9.7 ounce can of Fabreeze Air Effects. Review of the label on the can indicated "Keep Out of Reach of Children".		All Licensed Nurses will be in-serviced on the procedure for investigating incidents, including bruises by Sept. 30, 2011. **2.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** A. All staff including the therapists were re-educated 9-20-11 regarding the need for securing all hazardous materials. All staff was instructed to remove key(s) from doors or cabinets in violation of safety practices. Department managers will make frequent rounds and monitor secure areas regularly to ensure hazardous materials are secured properly and no keys are left in locks. B. All incident reports will be brought to the interdisciplinary Clinical Meeting 5 days weekly to make sure that incidents have been thoroughly investigated and causative factors have been identified. **3.What measures will be put into place to ensure this practice does not recur?** A. Therapists were re-educated regarding ensuring hazardous materials are properly secured. All management and line staff are monitoring cabinet lock identified and have been instructed to retrieve key(s) if found.	

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	6. a can of Aero Disinfectant. Review of the Material Safety Data Sheet [MSDS] indicated: "May be irritating to eyes, skin, nose, throat and mucous membranes. May cause abdominal discomfort, nausea, vomiting and diarrhea." During an interview at this time with the Occupational Therapist #1, she indicated that the cabinet was normally locked because of the items in the cabinet. She indicated that as a rule, the cabinet was unlocked, the computer taken out of the cabinet and then the cabinet was re-locked but that she guessed she just forgot this time. On 9/9/2011 at 9:00 a.m., the Administrator presented a copy of the facility's current policy on "Chemical Storage". Review of this policy at this time indicated: "Purpose: The purpose of chemical storage is to properly store chemicals used in a designated location. Follow these steps when storing chemicals. Step 1. Follow manufacture's recommendations when storing all chemicals. 2. Secure all items labeled "Keep Out of Reach of Children" out of sight from wandering residents....9. Therapy cabinets which contain chemicals are locked at all times when unattended and keys not left in lock..."		A. The Administrator or designee will conduct random checks throughout the facility on varying shifts 5 days per week for 30 days, then 3 times per week for 30 days to ensure hazardous materials are secured properly and no keys are left in locks. In addition to the random checks done by the Administrator or designee, as part of the facility “guardian angel program” the departments managers shall make frequent rounds and monitor locked areas. If the manager(s) identify an unsecure area it shall be secured immediately and reported to the Administrator and Therapy Lead staff immediately. The Therapy Lead will ensure the area is secured at once. Once the resident’s needs have been taken care of, the Therapy Lead staff will address the identified issue(s) with the involved staff, including re-training as necessary and progressive	

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	On 9/9/2011 at noon, the Director of Nursing presented a list 8 residents who were identified as confused and ambulatory. (Residents #26, 30, 3, 11, 19, 24, 28 and 31) B. 1. Review of the clinical record for Resident #6 on 9/8/2011 at 10:05 a.m., indicated the resident had diagnoses which included, but were not limited to, cerebral palsy, osteoarthritis, immobility syndrome, and osteoporosis. A 6/22/2011 nursing note indicated the resident had sustained a bruise to her inner upper right arm - 3 x 1.5 cm [centimeter] purple in color - which the resident indicated she had caught it on the mechanical lift. Review of the 6/22/2011 Bruise Investigation by the former DoN indicated the resident told her she did it on the sit-to-stand lift during toileting transfer. Documentation was lacking of any further investigation into how the bruise happened. During an interview with the current DoN on 9/8/2011 at 1:40 p.m., she indicated there should have been a more thorough investigation into how the transfer went,		disciplinary action for continued noncompliance. The Administrator or designee will document the random checks using QA audit form F-323 and bring the results to the Standards of Care meeting at the next scheduled meeting that is held weekly. Department manager "guardian angel program" rounds shall be documented on the "guardian angel program" form and the results shall be reviewed by the interdisciplinary team at the next scheduled morning management meeting that is held at least 5 days per week. B. As stated above, all incident reports will be brought to the Clinical Meeting 5 days weekly to verify incidents were thoroughly investigated and include causative factors. Any interventions that are developed as a result of this interdisciplinary review will be updated on the resident's care plan and CNA assignment sheet. These processes and reviews will continue on an ongoing basis. **4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** **A.** The Administrator will bring the results of the QA audits to the weekly Standards of Care meeting, the monthly QA&A Committee meeting that is attended by the medical	

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	i.e. resident moved, CNA [certified nursing assistant] did not position the resident correctly, CNA was not adequately trained, etc. The DoN also indicated she was not able to track as to who the CNA was at the time of the bruise to provide any further information. 3.1-45(a)(1) 3.1-45(a)(2)		director for review and recommendations. The QA audit-323 will be done 5 days a week for 30 days, then weekly for the next 30 days. At that time, the audit tool will continue at a frequency determined by the QA&A Committee, and can be discontinued by the QA&A Committee when 100% compliance is achieved. This process will continue on an ongoing basis even when documented audits are no longer required by the QA&A Committee. **B.** All Licensed Nurses will be in-serviced on the procedure for investigating incidents, including bruises by Sept. 30, 2011. **B.** As stated above, all incident reports will be brought to the Clinical Meeting 5 days weekly to verify incidents were thoroughly investigated and include causative factors. The Director of Nursing will bring the results of the QA audits to the weekly Standards of Care meeting, the monthly QA&A Committee meeting that is attended by the medical director for review and	

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			recommendations. The QA audit-323 will be done 5 days a week for 30 days, then weekly for the next 30 days. At that time, the audit tool will continue at a frequency determined by the QA&A Committee, and can be discontinued by the QA&A Committee when 100% compliance is achieved. This process will continue on an ongoing basis even when documented audits are no longer required by the QA&A Committee. These processes and reviews will continue on an ongoing basis. **Date of compliance: October 8, 2011.**	
F0364 SS=F	Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, record review and interview, the facility failed to ensure that the temperatures were at/or below 41 degrees for chicken salad sandwiches and coleslaw on the lunch time tray line. This had the potential to effect 31 of 31 residents currently residing at facility.	F0364	**F364** **It is the policy of this facility that each resident receives and is provided food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.** **1.What corrective action will be accomplished for those residents**	10/08/2011

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	Findings include: On 9/8/2011 at 11:55 a.m., the tray line items included, but were not limited to; chicken salad sandwiches on wheat bread and coleslaw. Temperatures on tray line of chicken salad sandwiches, indicated a temperature at 51.4 Fahrenheit [F] and of the coleslaw, which had a temperature of 50 degree F. Cook # 1 also took temperatures at the same time which indicated readings of 60 degrees F for the chicken salad sandwich and 61 degrees F for the coleslaw. Cook # 1 removed thermometer # 1 and retrieved a new thermometer which indicated results of 59 degrees F and 62 degrees F. On 9/8/2011 at 12:10 a.m., the Dietary Manager indicated that the cook "just took temps [temperature]." On 9/8/2011 at 12:12 a.m., Cook # 1 indicated that she had "just took the temps just before bringing the food out to tray line and they were below 40 degrees F." On 9/8/2011 at 12:15 a.m., during an observation of the tray line after temperatures were taken, the Administrator sent the sandwiches back to kitchen and new chicken salad sandwiches were brought out. A new temperature of the sandwiches resulted in		**found to have been affected by the deficiency?** No residents were found to be affected. Foods which tested at an unacceptable temperature were removed promptly and discarded. A replacement was provided immediately. **2567 pg. 13 indicates that requested temperature logs was lacking for 9/5 through 9/9/11. This is incorrect in that the logs were located on the back of the kitchen door and facility copies indicate they are complete and within policy guidelines. (See attached)** Food temps were acceptable when taken out of kitchen, per cook and facility documentation. When residents were waiting for food temps to be re-checked, Surveyor told Administrator and DSM to go ahead and start tray line to allow residents who were already waiting to proceed. Thermometers were calibrated immediately. **2.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** All residents had the potential to be affected by this practice. As stated previously all dietary staff has been in-serviced on how to check, when to check and how to document food temperatures, and policy on	

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	54.1 degrees F and the results were shown to the Dietary Manager. On 9/8/2011 at 12:15 a.m., during observation of the tray line, residents were being served by, but not limited to; Administrator and Dietary Manager. 4 residents were observed to have been served before the process was stopped and the Administrator and Dietary Manager was informed the chicken salad sandwiches and coleslaw could not be served based on their respective temperatures. On 9/8/2011 at 1:30 p.m., observation of the 3 thermometers used to test the food items, including the 2 by the facility, were placed in a glass of ice water. Thermometer # 1 of facility was observed to be at 38 degrees F and thermometer # 2 of the facility was observed to be at 40 degrees F. The third thermometer used was observed to be at 33.1 degrees F. On 9/8/2011 at 2:20 p.m., during an interview with the Administrator, she indicated that the 4 residents who had been served the sandwiches and coleslaw, had the sandwiches and coleslaw removed before any had been consumed and the residents had been offered alternatives. On 9/8/2011 at 2:20 p.m., in an interview		thermometer calibration. Additional education was completed one on one and in a group on 9-20-11. **3.What measures will be put into place to ensure this practice does not recur?** All dietary staff has been in-serviced on how to check, when to check and how to document food temperatures, including thermometer calibration. Additional education was completed one on one and in a group on 9-20-11. A Thermometer calibration log has been posted. The DSM or her designee will check the logs at each meal and make adjustments as indicated. The Dietary Services Manager or designee will conduct random checks daily on varying shifts 5 days per week for 60 days, then 3 times per week for 30 days to ensure food temperatures have been taken and documented. She will also take additional temps herself to verify accuracy. A Teachable Moment (discipline) was given to the DSM regarding the need to ensure food thermometer is calibrated routinely. If the DSM or designee finds holes in documentation or	

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	with the Dietary Manager, she indicated that she did not know when the thermometers had been last calibrated. On 9/9/2011 at 12:30 p.m., review of the Policy of Meal Temperatures presented by the Administrator indicated, but was not limited to; "Thermometers may be tested for accuracy by.....or ice water for a reading of 32 degrees." "Chilled foods should be held below 40 degrees F [Fahrenheit] to insure [sic] service temperatures that so not exceed 42 degrees F." On 9/9/2011 at 12:50 p.m., a record review of requested temperature logs indicated documentation was lacking for 9/5 through 9/9/2011. 3.1-21(a)(2)		differences with the temperatures the DSM or designee will immediately review area of concern with dietary staff involved and replace food items indicated. Once the resident's needs have been taken care of, the DSM will address the identified issue(s) with the involved staff, including re-training as necessary and progressive disciplinary action for continued noncompliance. The DSM or designee reviewing the documentation and taking additional temps will complete the QA audit form F364 at least 5 days per week and bring the results to the interdisciplinary team meeting at the next scheduled morning management meeting that is held at least 5 days per week. These processes and reviews will continue on an ongoing basis. **4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** The DSM will bring the results of the QA audits to the monthly QA&A Committee meeting that is attended by the medical director for review and recommendations. The QA audit-364 will be done 5 days a week for 60 days,	

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			then weekly for the next 30 days. At that time, the audit tool will continue at a frequency determined by the QA&A Committee, and can be discontinued by the QA&A Committee when 100% compliance is achieved. This process and review of the temperature logs and additional temperature checks will continue on an ongoing basis even when documented audits are no longer required by the QA&A Committee. **Date of compliance: October 8, 2011.**	
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on record review, observation and interview the facility failed to ensure that food items that had been opened and/or were left overs had been properly labeled and dated; failed to ensure that 3 pitchers in the refrigerator were free from particles of unknown origin on the pouring spout and properly covered to prevent cross contamination; and failed to dispose of outdated food product. This	F0371	**F371** **It is the policy of this facility to store, prepare, distribute and serve food under sanitary conditions.** **1.What corrective action will be accomplished for those residents found to have been affected by the deficiency?** No residents were affected.	10/08/2011

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	deficient practice had the potential to affect 31 of 31 residents who currently reside in the facility and received meals prepared in the facility kitchen. Findings include: On 9/6/2011 at 9:30 a.m., during the initial tour of the kitchen refrigerator it had; but was not limited to, the following food items without a date and/or identifying label; 1. a large approximately 2 quart container of brown gelatinous substance that the Dietary Manager identified as gravy 2. a container of cottage cheese 64 ounce (oz) one quarter full 3. a 64 oz. pitcher of pink substance marked milk shake 4. two 64 oz pitchers of iced tea # 1 half full and # 2 full 5. a large approximately 2 quart container of brown substance that the Dietary Manager identified as barbecue sauce 6. a large approximately 2 quart container of unidentified food for Resident # 30. Two 64 oz pitchers of iced tea and a 64		Items found stored incorrectly in the refrigerator were discarded immediately. 3 pitchers with lids in the refrigerator that did not seal completely and whose contents had leaked onto spout and dried were discarded and replaced. Items that were found without label of date and contents were discarded immediately. **2.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** All residents have the potential to be affected by this practice. Administrator or her designee will audit dietary department during daily rounds and record findings on form QA F371. During daily rounds, if any staff is observed not to follow the facility policies and procedures in regards to storing, preparing, distributing and serving food under sanitary conditions, the DSM or her designee will stop the staff person at that time, and immediately have him/her correct the area of concern. Once that is done, the DSM will in-service the staff involved on the facility policy and procedure for storing, preparing, distributing and serving food under sanitary conditions. She will also render	

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	oz. pitcher marked milk shake had covers but were missing the spout cover allowing a one inch circumference open to air and each of these covers had black, green, blue, white and pink substances around spout and on the covers. A large approximately 2 quart container of marked caramel sauce dated 6/6 was found in the refrigerator. On 9/6/2011 at 10:40 a.m., record review of the dietary's daily cleaning schedules dated from 8/1/2011 to 8/28/2011 lacked documentation that the area marked "Discard outdated food" had been done. On 9/6/2011 at 1:10 a.m., in an interview with the Dietary Manager she indicated that she was responsible to ensure that tasks were done and paper work had been properly signed upon completion of task. On 9/9/2011 at 11:04 a.m., record review of [name] facility job description for position title Dietary Supervisor, under section "B. Dietary Services Functions" included, but was not limited to; "Meet or exceed Company policies and state and federal regulations regarding sanitation..." under section "C. Food Preparation and Serving Functions" included, but was not limited to; ".....ensuring proper preparation and storage of food..."		progressive discipline for continued noncompliance. **3.What measures will be put into place to ensure this practice does not recur?** As stated above, Administrator or her designee will conduct daily rounds and audit dietary department and record findings on form QA F371. During daily rounds, if any staff is observed not to follow the facility policies and procedures in regards to storing, preparing, distributing and serving food under sanitary conditions, the DSM or her designee will stop the staff person at that time, and immediately have him/her correct the area of concern. The Administrator in-serviced all dietary staff on the policy and procedure to store, prepare, distribute and serve food under sanitary conditions one on one and in group on Sept. 20, 2011. The Dietary Services Manager or designee will perform random observations, including tray line temperatures, 5 day per week for 60 days, then 3 times per week for 30 days to ensure temperatures are at levels appropriate for serving residents. The DSM or her designee will complete the QA audit form F441 at least 5 days per week and bring the results to the	

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	"Dietary Services Manager Skills Checklist" included, but was not limited to; under section "4. Sanitation/Physical Plant, *cleaning schedules" was initialed by the Dietary Manager on 6/22/2011 as being completed. "Food Preparation and Service, *food storage, *handling of leftovers" were both dated as completed on 6/22/2011. "COOK TRAINING CHECKLIST" included, but was not limited to; under section "2. Meal Preparation *cover, date, & labor [sic] stored foods", under section "5. Patient Tray Line and Meal Service *know proper food storage". Checklist signed on 2/26/2010 by the Dietary Manager indicated she had been trained. 3.1-21(i)(3)		interdisciplinary team meting at the next scheduled morning management meeting that is held at least 5 days per week. These processes and reviews will continue on an ongoing basis. **4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** The DSM will bring the results of the QA audits to the interdisciplinary team meeting 5 days per week, and the monthly QA&A Committee meeting that is attended by the medical director for review and recommendations. The QA audit-F441 will be done 5 days a week for 60 days, then weekly for the next 30 days. At that time, the audit tool will continue at a frequency determined by the QA&A Committee, and can be discontinued by the QA&A Committee when 100% compliance is achieved. This process will continue on an ongoing basis even when documented audits are no longer required by the QA&A	

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure changes in medication orders and pulse monitoring checks were complete, accurately documented and/or readily accessible for 2 of 10 residents in a sample of 10 residents (Residents #6 and 28) reviewed for medication orders, and 1 of 4 residents reviewed for weights in a sample of 10 residents.(Resident #1) Findings include: 1. Review of the clinical record for Resident #6 on 9/8/2011 at 10:05 a.m., indicated the resident had diagnoses which included, but were not limited to, cerebral palsy, osteoarthritis, immobility syndrome, and osteoporosis.	F0514	Committee. **Date of compliance: October 8, 2011.** **F514** **It is the policy of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systemically organized.** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** 1. Medication (Motrin) for Resident #6 was added to the Medication Administration Record on August 30, 2011. 2. The MD was notified of pulse checks for Resident #28 on 9/9/11. MD gave a new order to discontinue daily pulse checks and to check pulse	10/07/2011

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	On 8/22/2011, the consultant pharmacist made a recommendation for the physician to re-evaluate the resident's Motrin [a non-steroid anti-inflammatory drug] 400 mg [milligram] BID [twice daily] due to long term use being associated with elevated blood pressure, worsening kidney function, cardiovascular events and GI effects." On 8/26/2011, the physician agreed and gave a new order to decrease the Motrin to 200 mg po [by mouth] BID. Review of the August MAR [Medication Administration Record] indicated the order was not put into effect until 8/30/2011. During an interview with the Director of Nursing [DoN] on 9/8/2011 at 2:00 p.m., she indicated one of the nurses' found the consultant's recommendation and the physician's response on a clip board 4 days later which was why the medication was not reduced until 8/30/2011. She also indicated the nurse did not know she needed to write an order. 2. Review of the clinical record for Resident #28 on 9/7/2011 at 3:15 p.m., indicated the resident had diagnoses which included, but were not limited to, coronary artery disease, atrial fibrillation		every other day with Digoxin on 9/9/11. The DON will provide re education to the nurses/QMAs on 9/28/11 to include review of Pharmacy recommendations and transcription of orders for medication changes and vital sign monitoring. 4. Resident # 1's dietary progress note was corrected to address her weight. **2.How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken?** 1. A Pharmacy recommendation audit was completed on 9/12/11. No other residents were found to be affected by this alleged deficient practice. 2 . An audit will be conducted by 9/30/11 on all monthly rewrites to make sure that they are accurate in preparation for the review of the October monthly physician orders. As the DON is reviewing the September monthly physician orders and any physician orders subsequent to it, she will identify any issues or concerns regarding physician orders and will make sure that the physician is notified, as necessary, for clarification. Once the orders are complete and accurate, the DON will review the facility's policy for	

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	155417	A. BUILDING 00 B. WING	09/09/2011

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	and hypertension. The 2011 September monthly physician orders indicated the resident had an order dated 7/19/2010 for pulse checks every day. Review of the May to August 2011 MARs lacked documentation of the pulse being monitored on a daily basis. During an interview with the DoN on 9/9/2011 at 11:00 a.m., she indicated she was not aware the pulse was not being monitored daily per physician orders and would need to call the physician to determine the reasoning for it being monitored daily and if he wanted it to continue to be monitored daily.		transcription and following of physician orders with the nurse(s) involved. She will also render progressive disciplinary action for continued noncompliance. 3. An audit will be conducted by 9/30/11 on all dietary progress notes. **3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON will review the 24 hour report, focus charting, Medication Administration Record, and Physician orders at least five times a week as part of her daily tour of duty. Pharmacy recommendations will be given to the nurses to fax to the MDs. The MDs that do not receive faxes will be called in regards to the recommendations. If no response is received within 24 hours, the Physician will be contacted by phone for follow up. The DON will in-service all licensed nurses on this policy on 9/28/11.	

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			At least five days per week, the DON or designee, will review the 24 hour report, focus charting, Medication Administration Record, and Physician orders for any outstanding recommendations or change of orders. The DON or designee will document findings on audit tool QA audit form F282, five days per week. If the DON identifies recommendations not addressed by the Physician or new orders not processed, she will immediately ensure the attending Physician is notified and process any orders. Once they have been corrected, the DON will re train the staff member(s) involved. In addition, progressive disciplinary actions will be taken for non compliance. The RD/DSM will correct any discrepancies regarding weight documentation. **4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?**	

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	3. On 9/6/2011 at 11:00 a.m., record review of Resident # 1 indicated, but was not limited to; diagnoses of Huntington's chorea and obesity. Review of the Monthly/Annual vital sign and weight record indicated, but was not limited to, weight for May had been 197.5 lbs[pounds], June was 195 lbs, July was 193 lbs, August was 193 lbs and September was 194 lbs.		The DON or designee will bring the QA audits to the clinical review meeting 5 days a week. In addition, the results of the QA audit tool will be reviewed weekly at the Standards of Care meeting and monthly at the QA committee meeting for the next 3 months. The Dietary Services Manager will also bring the results of her review regarding any discrepancies in recording of residents' weights to the QA Committee monthly for the next 3 months. The QA committee will determine the continued frequency of the QA audit tools after the 3 month time period once the facility demonstrates 100% compliance. However, the review process as outlined above will continue on an ongoing basis, even when the Committee no longer requires a written audit. Date of compliance is October 7 th , 2011.	

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	Review of the "DIETARY PROGRESS NOTES" dated 8/15/2011 indicated, but was not limited to; "Sig [significant] wt [weight] (symbol for change) - current wt is 140 # [pounds]. Past weight 5/11 146.5, 6/11 143, 7/11 146.6 a 4.1 % [percent] loss." On 9/6/2011 at 5:50 p.m. in an interview with the Dietary Manager, when asked about the charting discrepancy she remained silent and did not give any comment. On 9/9/2011 at 11:04 a.m., review of the Dietary Services Manager skills checklist under section "6. Clinical/Nutritional *assessments-initial, quarterly" dated and signed by the Dietary Manager on 6/29/2011 indicated that this skill had been completed. On 9/9/2011 at 1:30 p.m., the Administrator produced an amended dietary progress note dated 9/7/2011 which indicated "Wt's [weight's] on above dietary note was recorded wrong. Wt for 8/4/2011 at 193 #'s [pound's], was stable 30 days. Wt on 9/11 at 194 #'s. Above wts recorded on wrong resident. No sign [significant] wt (symbol for change) in last 180 days."			

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